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National Health Policy

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
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Introductory

1. The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner.

1.2 Since the inception of the planning process in the country, the successive Five Year Plans have been providing the framework within which the States may develop their health services infrastructure, facilities for medical education, research, etc. Similar guidance has sought to be provided through the discussions and conclusions arrived at in the Joint Conferences of the Central Councils of Health and Family Welfare and the National Development Council. Besides, Central legislation has been enacted to regulate standards of medical education, prevention of food adulteration, maintenance of standards in the manufacture and sale of certified drugs, etc.

1.3 While the broad approaches contained in the successive Plan documents and discussions in the forums referred to in para 1.2 may have generally served the needs of the situation in the past, it is felt that an integrated, comprehensive approach towards the future development of medical education, research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health Policy.

Our heritage

2. India has a rich, centuries-old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical skills enunciated by Charaka and Shusharuta bear testimony to our ancient tradition in the scientific health care of our people. The

approach of our ancient medical systems was of a holistic nature, which took into account all aspects of human health and disease. Over the centuries, with the intrusion of foreign influences and mingling of cultures, various systems of medicine evolved and have continued to be practised widely. However, the allopathic system of medicine has, in a relatively short period of time, made a major impact on the entire approach to health care and pattern of development of the health services infrastructure in the country.

Progress achieved

3. During the last three decades and more, since the attainment of Independence, considerable progress has been achieved in the promotion of the health status of our people. Smallpox has been eliminated; plague is no longer a problem; mortality from cholera and related diseases has decreased and malaria brought under control to a considerable extent. The mortality rate per thousand of population has been reduced from 27.4 to 14.8 and the life expectancy at birth has increased from 32.7 to over 52. A fairly extensive network of dispensaries, hospitals and institutions providing specialised curative care has developed and a large stock of medical and health personnel, of various levels, has become available. Significant indigenous capacity has been established for the production of drugs and pharmaceuticals, vaccines, sera, hospital equipments, etc.

The existing picture

4. In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated. Blindness, Leprosy and T.B. continue to have a high incidence. Only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation.

4.1. High incidence of diarrhoeal diseases and other preventive and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

4.2. The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

Need for evolving a health policy— the revised 20-Point Programme

5. India is committed to attaining the goal of "Health for All by the Year 2000 A.D." through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. Furthermore, considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, specially in the more closely health related sectors, e.g. drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and the conservation of the environment. In sum, the contours of the National Health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal, comprehensive primary health care services, relevant to the actual

needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the Health sector.

5.1. It is also necessary to ensure that the pattern of development of the health services infrastructure in the future fully takes into account the revised 20-Point Programme. The said Programme attributes very high priority to the promotion of family planning as a people's programme, on a voluntary basis; substantial augmentation and provision of primary health care facilities on a universal basis; control of Leprosy, T.B. and Blindness; acceleration of welfare programmes for women and children; nutrition programmes for pregnant women, nursing mothers and children, especially in the tribal, hill and backward areas. The Programme also places high emphasis on the supply of drinking water to all problem villages, improvements in the housing and environments of the weaker sections of society; increased production of essential food items; integrated rural developments; spread of universal elementary education; expansion of the public distribution system, etc.

Population stabilisation

6. Irrespective of the changes, no matter how fundamental, that may be brought about in the over-all approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation. In view of the vital importance of securing the balanced growth of the population, it is necessary to enunciate, separately, a National Population Policy.

Medical and Health Education

7. It is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a coordinated action programme. It is, therefore, of crucial importance that the entire basis and approach towards medical and health education, at all levels, is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socially motivated to effectively deal with day-to-day problems, within the existing constraints.

Towards this end, it is necessary to formulate, separately, a National Medical and Health Education Policy which (i) sets out the changes required to be brought about in the curricular contents and training programme of medical and health personnel, at various levels of functioning; (ii) takes into account the need for establishing the extremely essential inter-relations between functionaries of various grades; (iii) provides guidelines for the production of health personnel on the basis of realistically assessed manpower requirements; (iv) seeks to resolve the existing sharp regional imbalances in their availability; and (v) ensures that personnel at all levels are socially motivated towards the rendering of community health services.

Need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects

8. Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres—dispensaries, hospitals, institutions for specialist treatment—the large majority of which are located in the urban areas of the country. The vast majority of those seeking medical relief have to travel long distance to the nearest curative centre, seeking relief for ailments which could have been readily and effectively handled at the community level. Also, for want of a well established referral system, those seeking curative care have the tendency to visit various specialist centres, thus further contributing to congestions, duplication of efforts and consequential waste of resources. To put an end to the existing all-round unsatisfactory situation, it is urgently necessary to restructure the health services within the following broad approach :

- (1) To provide, within a phased, time-bound programme a well dispersed network of comprehensive primary health care services, integrally linked with the extension and health education approach which takes into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves, with the organised support of volunteers, auxiliaries, para-medics and adequately trained multi-purpose workers of various grades of skill and competence, of both sexes. There are a large number of private, voluntary organisations active in the health field, all over the country. Their services and support would require to be utilised and intermeshed with the governmental efforts, in an integrated manner.
- (2) To be effective, the establishment of the primary health care approach would involve large scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence. The functioning of the front line workers, selected by the

community would require to be related to definitive action plans for the translation of medical and health knowledge into practical action, involving the use of simple and inexpensive interventions which can be readily implemented by persons who have undergone short periods of training. The quality of training of these health guides/workers would be of crucial importance to the success of this approach.

- The success of the decentralised primary health care system would depend vitally on the organised building up of individual self-reliance and effective community participation; on the provision of organised, back-up support of the secondary and tertiary levels of the health care services, providing adequate logistical and technical assistance.
- (4) The decentralisation of services would require the establishment of a well worked out referral system to provide adequate expertise at the various levels of the organisational set-up nearest to the community, depending upon the actual needs and problems of the area, and thus ensure against the continuation of the existing rush towards the curative centres in the urban areas. The effective establishment of the referral system would also ensure the optimal utilisation of expertise at the higher levels of the hierarchical structure. This approach would not only lead to the progressive improvement of comprehensive health care services at the primary level but also provide for timely attention being available to those in need of urgent specialist care, whether they live in the rural or the urban areas.
 - (5) To ensure that the approach to health care does not merely constitute a collection of disparate health interventions but consists of an integrated package of services seeking to tackle the entire range of poor health conditions, on a broad front, it is necessary to establish a nation-wide chain of sanitary-cum-epidemiological stations. The location and functioning of these stations may be between the primary and secondary levels of the hierarchical structure, depending upon the local situations and other relevant considerations. Each such station would require to have suitably trained staff equipped to identify, plan and provide preventive, promotive and mental health care services. It would be beneficial, depending upon the local situations, to establish such stations at the Primary Health Centres. The district health organisation should have, as an integral part of its set-up, a well organised epidemiological unit to coordinate and superintend the functioning of the field stations. These stations would participate in the integrated action plans to eradicate and control diseases, besides tackling specific local environmental health problems.

In the urban agglomerations, the municipal and local authorities should be equipped to perform similar functions, being supported with adequate resources and expertise, to effectively deal with the local preventable public health problems. The aforesaid approach should be implemented and extended through community participation and contributions, in whatever form possible, to achieve meaningful results within a time-bound programme.

- (6) The location of curative centres should be related to the populations they serve, keeping in view the densities of population, distances, topography, transport connections. These centres should function within the recommended referral system, the gamut of the general specialities required to deal with the local disease patterns being provided as near to the community as possible, at the secondary level of the hierarchical organisation. The concept of domiciliary care and the field-camps approach should be utilised to the fullest extent, to reduce the pressures on these centres, specially in efforts relating to the control and eradication of Blindness, Tuberculosis, Leprosy, etc. To maximise the utilisation of available resources, new and additional curative centres should be established only in exceptional cases, the basic attempt being towards the upgradation of existing facilities, at selected locations, the guiding principle being to provide specialist services as near to the beneficiaries as may be possible, within a well-planned network. Expenditure should be reduced through the fullest possible use of cheap locally available building materials, resort to appropriate architectural designs and engineering concepts and by economical investment in the purchase of machineries and equipments, ensuring against avoidable duplication of such acquisitions. It is also necessary to devise effective mechanisms for the repair, maintenance and proper upkeep of all bio-medical equipments to secure their maximum utilisation.
- (7) With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professional, increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field.
- (8) While the major focus of attention in restructuring the existing governmental health organisations would relate to establishing comprehensive

primary health care and public health services, within an integrated referral system, planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super-speciality services, through a well dispersed network of centres, to ensure that the present and future requirements of specialist treatment are adequately available within the country. To reduce governmental expenditures involved in the establishment of such centres, planned efforts should be made to encourage private investments in such fields so that the majority of such centres, within the governmental set-up, can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by the paying clinics. Care would also require to be taken to ensure the appropriate dispersal of such centres, to remove the existing regional imbalances and to provide services within the reach of all, whether residing in the rural or the urban areas.

- (9) Special, well-coordinated programmes should be launched to provide mental health care as well as medical care and the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged. Also, suitably organised programmes would require to be launched to ensure against the prevention of various disabilities.
- (10) In the establishment of the re-organised services, the first priority should be accorded to provide services to those residing in the tribal, hill and backward areas as well as to endemic disease affected populations and the vulnerable sections of the society.
- (11) In the re-organised health services scheme, efforts should be made to ensure adequate mobility of personnel, at all levels of functioning.
- (12) In the various approaches, set out in (1) to (11) above, organised efforts would require to be made to fully utilise and assist in the enlargement of the services being provided by private voluntary organisations active in the health field. In this context, planning encouragement and support would also require to be afforded to fresh voluntary efforts, specially those which seek to serve the needs of the rural areas and the urban slums.

Re-orientation of the existing health personnel

9. A dynamic process of change and innovation is required to be brought about in the entire approach to health manpower development, ensuring the emergence of fully integrated bands of workers functioning within the "Health Team" approach.

Private practice by governmental functionaries

10. It is desirable for the States to take steps to phase out the system of private practice by medical personnel in government service, providing at the same time for payment of appropriate compensatory non-practising allowance. The States would require to carefully review the existing situation, with special reference to the availability and dispersal of private practitioners, and take timely decisions in regard to this vital issue.

Practitioners of indigenous and other systems of medicine and their role in health care

11. The country has a large stock of health manpower comprising of private practitioners in various systems, for example, Ayurveda, Unani, Sidha, Homoeopathy, Yoga, Naturopathy, etc. This resource has not so far been adequately utilised. The practitioners of these various systems enjoy high local acceptance and respect and consequently exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned efforts should be made to dovetail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system, specially in regard to the preventive, promotive and public health objectives. Well considered steps would also require to be launched to move towards a meaningful phased integration of the indigenous and the modern systems.

Problems requiring urgent attention

12. Besides the recommended restructuring of the health services infrastructure, reorientation of the medical and health manpower, community involvement and exploitation of the services of private medical practitioners, specially those of the traditional and other systems, involvement and utilisation of the services of the voluntary agencies active in the health field, etc., it would be necessary to devote planned, time-bound attention to some of the more important inputs required for improved health care. Of these, priority attention would require to be devoted to :

- (i) **Nutrition** : National and regional strategies should be evolved and implemented, on a time-bound basis, to ensure adequate nutrition for all segments of the population through a well developed distribution system, specially in the rural areas and urban slums. Food of acceptable quality



must be available to every person in accordance with his physical needs. Low cost, processed and ready-to-eat foods should be produced and made readily available. The over-all strategy would necessarily involve organised efforts at improving the purchasing power of the poorer sections of the society. Schemes like employment guarantee scheme, to which the government is committed could yield optimal results if these are suitably linked to the objective of providing adequate nutrition and health cover to the rural and the urban poor. The achievement of this objective is dependent on integrated socio-economic development leading to the generation of productive employment for all those constituting the labour force. Employment guarantee scheme and similar efforts would require to be specially enforced to provide social security for identified vulnerable sections of the society. Measures aimed at improving eating habits, inculcation of desirable nutritional practices, improved and scientific utilisation of available food materials and the effective popularisation of improved cooking practices would require to be implemented. Besides, a nation-wide programme to promote breast feeding of infants and eradication of various social taboos detrimental to the promotion of health would need to be initiated. Simultaneously, the problems of communities afflicted by chronic nutritional disorders should be tackled through special schemes including the organisation of supplementary feeding programmes directed to the vulnerable sections of the population. The force and effect of such programmes should be ensured by delivering them within the setting of fully integrated health care activities, to ensure the inculcation of the educational aspects, in the over-all strategy.

- (ii) *Prevention of food adulteration and maintenance of the quality of drugs :* Stringent measures are required to be taken to check and prevent the adulteration and contamination of foods at the various stages of their production, processing, storage, transport, distribution, etc. To ensure uniformity of approach, the existing laws would require to be reviewed and effective legislation enacted by the Centre. Similarly, the most urgent measures require to be taken to ensure against the manufacture and sale of spurious and sub-standard drugs.
- (iii) *Water supply and sanitation :* The provision of safe drinking water and the sanitary disposal of waste waters, human and animal wastes, both in urban and rural areas, must constitute an integrated package. The enormous backlog in the provision of these services to the rural population and in the urban agglomerations must be made up on the most urgent basis. The provision of water supply and basic sanitation facilities would

not automatically improve health. The availability of such facilities should be accompanied by intensive health education campaigns for the improvement of personal hygiene, the economical use of water and the sanitary disposal of waste in a manner that will improve individual and community health. All water-supply schemes must be fully integrated with efforts at proper water management, including the drainage and disposal of waste waters. To reduce expenditures and for achieving a quick headway it would be necessary to devise appropriate technologies in the planning and management of the delivery systems. Besides, the involvement of the community in the implementation and management of the systems would be of crucial importance, both for reducing costs as well as to see that the beneficiaries value and protect the services provided to them.

- (iv) *Environmental protection* : While preventive, promotive, public health services are established and the curative services re-organised to prevent, control and treat diseases, it would be equally necessary to ensure against the haphazard exploitation of resources which cause ecological disturbances leading to fresh health hazards. It is, therefore, necessary that economic development plans, in the various sectors, are devised in adequate consultation with the Central and the State Health authorities. It is also vitally essential to ensure that the present and future industrial and urban development plans are centrally reviewed to ensure against congestions, the unchecked release of noxious emissions and the pollution of air and water. In this context, it is vital to ensure that the siting and location of all manufacturing units is strictly regulated, through legal measures, if necessary. Central and State Health authorities must necessarily be consulted in establishing locational policies for industrial development and urbanisation programmes. Environmental appraisal procedures must be developed and strictly applied in according clearance to the various developmental projects.
- (v) *Immunisation programme* : It is necessary to launch an organised, nation-wide immunisation programme, aimed at cent percent coverage of targetted population groups with vaccines against preventable and communicable diseases. Such an approach would not only prevent and reduce disease and disability but also bring down the existing high infant and child mortality rate.
- (vi) *Maternal and Child Health Services* : A vicious relationship exists between high birth rates and high infant mortality, contributing to the desire for



more children. The highest priority would, therefore, require to be devoted to efforts at launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of society. Such programmes would require to be decentralised to the maximum possible extent, their delivery being at the primary level, nearest to the doorsteps of the beneficiaries. While efforts should continue at providing refresher training and orientation to the traditional birth attendants, schemes and programmes should be launched to ensure that progressively all deliveries are conducted by competently trained persons so that complicated cases receive timely and expert attention, within a comprehensive programme providing ante-natal, intra-natal and post-natal care.

- (vii) *School health programme* : Organised school health services, integrally linked with the general, preventive and curative services, would require to be established within a time-limited programmes.
- (viii) *Occupational health services* . There is urgent need for launching well-considered schemes to prevent and treat diseases and injuries arising from occupational hazards, not only in the various industries but also in the comparatively un-organised sectors like agriculture. For this purpose, the coverage of the Employees State Insurance Act, 1948, may be suitably extended ensuring adequate coordination of efforts with the general health services. In their respective spheres of responsibility, the Centre and the States must introduce organised occupational health services to reduce morbidity, disabilities and mortality and thus promote better health and increased welfare and productivity on all fronts.

Health education

13. The recommended efforts, on various fronts, would bear only marginal results unless nation-wide health education programmes, backed by appropriate communication strategies are launched to provide health information in easily understandable form, to motivate the development of an attitude for healthy living. The public health education programmes should be supplemented by health, nutrition and population education programmes in all educational institutions, at various levels. Simultaneously, efforts would require to be made to promote universal education, specially adult and family education, without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal and child health cannot bear fruit.

Management information system

14. Appropriate decision making and programme planning in the health and related fields is not possible without establishing an effective health information system. A nation-wide organisational set-up should be established to procure essential health information. Such information is required not only for assisting in planning and decision making but to also provide timely warnings about emerging health problems and for reviewing, monitoring and evaluating the various on-going health programmes. The building up of a well conceived health information system is also necessary for assessing medical and health manpower requirements and taking timely decisions, on a continuing basis, regarding the manpower requirements in the future.

Medical industry

15. The country has built up sound technological and manufacturing capability in the field of drugs, vaccines, bio-medical equipments, etc. The available know-how requires to be adequately exploited to increase the production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirements, specially in regard to the national programmes to combat Malaria, TB, Leprosy, Blindness, Diarrhoeal diseases, etc. The production of the essential, life saving drugs under their generic names and the adoption of economical packaging practices would considerably reduce the unit cost of medicines bringing them within the reach of the poorer sections of society, besides significantly reducing the expenditures being incurred by the governmental organisation on the purchase of drugs. In view of the low cost of indigenous and herbal medicines, organised efforts may be launched to establish herbal gardens, producing drugs of certified quality and making them easily available.

15.1 The practitioners of the modern medical system rely heavily on diagnostic aids involving extensive use of costly, sophisticated bio-medical equipment. Effective mechanisms should be established to identify essential equipments required for extensive use and to promote and enlarge their indigenous manufacture, for such devices being readily available, at reasonable prices, for use at the health care centres.

Health insurance

16. Besides mobilising the community resources, through its active participation in the implementation and management of national health and related programmes, it would be necessary to device well considered health insurance schemes, on a State-wise basis, for mobilising additional resources for health promotion and ensuring that the community shares the cost of the services, in keeping with its paying capacity.

Health legislation

17. It is necessary to urgently review all existing legislation and work towards a unified, comprehensive legislation in the health field, enforceable all over the country.

Medical research

18. The frontiers of the medical sciences are expanding at a phenomenal pace. To maintain the country's lead in this field as well as to ensure self-sufficiency and generation of the requisite competence in the future, it is necessary to have an organised programme for the building up and extension of fundamental and basic research in the field of bio-medical and allied sciences. Priority attention would require to be devoted to the resolution of problems relating to the containment and eradication of the existing, widely prevalent diseases as well as to deal with emerging health problems. The basic objective of medical research and the ultimate test of its utility would involve the translation of available know-how into simple, low-cost, easily applicable appropriate technologies, devices and interventions suiting local conditions, thus placing the latest technological achievements, within the reach of health personnel, and to the front line health workers, in the remotest corners of the country. Therefore, besides devotion to basic, fundamental research, high priority should be accorded to applied, operational research including action research for continuously improving the cost effective delivery of health services. Priorities would require to be identified and laid down in collaboration with social scientists, planners and decision makers and the public. Basic research efforts should devote high priority to the discovery and development of more effective treatment and preventive procedures in regard to communicable and tropical diseases—Blindness, Leprosy, T.B., etc. Very high priority would also have to be devoted to contraception research, to urgently improve the effectiveness and acceptability of existing methods as well as to discover more effective and acceptable devices. Equally high attention would require to be devoted to nutrition research, to improve the health status of the community. The overall effort should aim at the balanced development of basic, clinical and problem-oriented operational research.

Inter-sectoral cooperation

19. All health and human development must ultimately constitute an integral component of the overall socio-economic developmental process in the country. It is thus of vital importance to ensure effective coordination between the health and its more intimately related sectors. It is, therefore, necessary to set up standing mechanisms, at the Centre and in the States, for securing inter-sectoral coordination of the various

efforts in the fields of health and family planning, medical education and research, drugs and pharmaceuticals, agriculture and food, water supply and drainage, housing, education and social welfare and rural development. The coordination and review committees, to be set up, should review progress, resolve bottlenecks and bring about such shifts in the contents and priorities of programmes as may appear necessary, to achieve the overall objectives. At the community level, it would be desirable to devise arrangements for health and all other developmental activities being coordinated under an integrated programme of rural development.

Monitoring and review of progress

20. It would be of crucial importance to monitor and periodically review, the success of the efforts made and the results achieved. For this purpose, it is necessary to urgently identify the base line situation and to evolve a phased programme for the achievement of short and long term objectives in the various sectors of activity. Towards this end, the current level of achievement as well as the broad indicators for the achievement of certain basic health and family welfare goals are set out in the annexed tabular statement. These goals, as well as other allied objectives, would require to be further worked upon and specific targets for achievement established by the Central and the State governments in regard to the various areas of functioning.

Goals for Health and Family Welfare Programmes

Sl. No.	Indicator	Current level	Goals		
			1985	1990	2000
1	2	3	4	5	6
1.	Infant mortality rate	Rural 136 (1978)	122		
		Urban 70 (1978)	60		
		Total 125 (1978)	106	87	below 60
	Perinatal mortality	67 (1976)			30-35
2.	Crude death rate	Around 14	12	10.4	9.0
3.	Pre-school child (1-5 yrs.) mortality	24 (1976-77)	20-24	15-20	10
4.	Maternal mortality rate	4-5 (1976)	3-4	2-3	below 2
5.	Life expectancy at birth (yrs.)	Male 52.6 (1976-81)	55.1	57.6	64
		Female 51.6 (1976-81)	54.3	57.1	64
6.	Babies with birth weight below 2500 gms. (percentage)	30	25	18	10
7.	Crude birth rate	Around 35	31	27.0	21.0
8.	Effective couple protection (percentage)	23.6 (March, 82)	37.0	42.0	60.0
9.	Net Reproduction Rate (NRR)	1.48 (1981)	1.34	1.17	1.00
10.	Growth rate (annual)	2.24 (1971-81)	1.90	1.66	1.20
11.	Family size	4.4 (1975)	3.8		2.3
12.	Pregnant mothers receiving ante-natal care (%)	40-50	50-60	60-75	100
13.	Deliveries by trained birth attendants (%)	30-35	50	80	100

1	2	3	4	5	6
14.	Immunisations status (% coverage)				
	TT (for pregnant women)	20	60	100	100
	TT (for school children)				
	10 years		40	100	100
	16 years	20	60	100	100
	DPT (children below 3 years)	25	70	85	85
	Polio (infants)	5	50	70	85
	BCG (infants)	65	70	80	85
	DT (new school entrants 5-6 years)	20	80	85	85
	Typhoid (new school entrants 5-6 years)	2	70	85	85
15.	Leprosy —percentage of disease arrested cases out of those detected				
		20	40	60	80
16.	TB—percentage of disease arrested cases out of those detected				
		50	60	75	90
17.	Blindness—Incidence of (%)				
		1.4	1	0.7	0.3